Michigan Department of Community Health

Medicaid Provider Manual
October 2004 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	10.3 Billing Limitations	The last paragraph of the subsection was reworded and reformatted to read as follows: "Providers who have claims meeting either of the first two exception criteria must contact their local FIA office to initiate the following exception process: • The FIA caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDCH. • FIA informs the provider when the MSA-1038 has been approved by MDCH. • Once informed of the approval, the provider prepares claims related to the exception, indicating "MSA-1038 approval on file" in the comment section. • The provider submits claims to MDCH through the normal submission process. Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission. Questions regarding claims submitted under this exception should be directed to MDCH Provider Inquiry. (Refer to the Directory Appendix for contact information)."	Revised for clarification.
Beneficiary Eligibility	1.5 Corrective Action (new subsection added)	The new subsection reads as follows: "Beneficiaries that have been denied Medicaid eligibility and have filed a hearing request may be entitled to a reimbursement if they paid for Medicaid covered services during a corrective action period. The corrective action period begins on the date the hearing request is received by the Family Independence Agency (FIA) and ends on the date that eligibility is established. The services received must have been provided during the established eligibility period, including any months of established retroactive eligibility. The provider has the option to reimburse the beneficiary in full and bill Medicaid for services rendered. MDCH encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider chooses not to reimburse the beneficiary, the beneficiary can request a direct reimbursement from the State.	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		In order to be eligible for a direct reimbursement from the State, the beneficiary, or someone legally responsible for the beneficiary's bills, must have paid for a Medicaid covered service during the corrective action period. The beneficiary cannot receive reimbursement for any required copays, patient pay amounts, amounts used to meet a spend-down, or care or services paid for through private insurance, Medicare, or any other form of government-sponsored or private health care coverage. To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received on or after February 2, 2004, for which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDCH. Bills must include or contain: • Beneficiary name; • Date the care or service was received; • Amount charged for the care or service; • Amount paid by the beneficiary or legally responsible party; • Date the bill was paid; • Procedure code(s) for the care or service; • Description of each care or service, e.g., office visit, physical therapy, etc. Drug name, quantity dispensed, and the name of the prescribing physician must be included for prescriptions; and • Proof of any payment made by a third party, such as an insurance company. "	
Beneficiary Eligibility	2.1 Scope/Coverage Codes	Under Scope Code 1, T and V were deleted.	Deleted obsolete information.
Beneficiary Eligibility	Section 10 – Children's Special Health Care Services	The 2nd bullet was modified as follows: • Persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.	Clarification added.

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CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.G. Special Considerations for Inpatient Hospital Claims	The 1st sentence of the 3rd bullet was modified as follows: • The actual total Medicare Part A and Part B payment, which includes contractual adjustment, must be indicated on the inpatient hospital claim/adjustment.	Correction/clarification.
Billing & Reimbursement for Institutional Providers	7.1 Revenue and CPT/HCPCS Codes	The description for Revenue Code 0942 was changed to Education/Training.	Correction
Billing & Reimbursement for Institutional Providers	8.8 Ancillary Physical and Occupational Therapy, Speech Pathology	Information contained in 8.13 Ancillary Care, was moved to 8.8. No changes were made to the content.	
Billing & Reimbursement for Institutional Providers	8.13 Ancillary Care	Subsection deleted, content moved to 8.8. Subsequent subsections renumbered.	
Billing & Reimbursement for Institutional Providers	9.4 Intravenous Infusions (new subsection added)	The new subsection reads as follows: "If the beneficiary is in need of intravenous infusion, and an Infusion Clinic or ancillary Medicaid provider (who has no nurse) does not cover the service or family member/caregiver will not accept this task, the HHA may perform this service and bill accordingly.	Clarification added to facilitate processing of claims.

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		These services must be billed as Infusion Nurse Visit. • Use Revenue Code 0550, 0551, or 0552 • Use Procedure Codes ➢ 99601 (first two hours). Must be billed on the first claim line. ➢ 99602 (each additional hour). Must be billed on each additional claim line for each additional hour. "	
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The following sentence was added to the 1st bullet after the Revenue Code table: "Room and board is reimbursable on the day of discharge only if the discharge is due to resident death." The following two bullets were added: • Services for day of discharge are reimbursable if services were rendered, regardless of the setting. (See first bullet for instructions regarding room and board.) • When billing for a hospice/NF resident with a Memorandum of Understanding (MOU), bill Revenue Code 0120 and include the assigned prior authorization (PA) number in F.L. 84.	Added for clarification
Children's Special Health Care Services Program	9.4 Case Management Benefit	The 2nd sentence in the 2nd paragraph was revised as follows: "Clients are eligible for a maximum of six billing units per eligibility year."	Clarification
Hospice	3.4.A. Beneficiary's Home	The 2nd paragraph was revised as follows: "Beneficiaries may receive hospice services in these settings. The hospice is responsible for developing and implementing a coordinated plan of care to avoid duplication of services. These care settings are available for Medicare, Medicaid, and dually eligible beneficiaries."	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospice	3.4.B. Nursing Facility	The following was inserted after the 3rd paragraph: "The Pre-Admission Screening/Annual Resident Review (PASARR) DCH-3877 form must be completed for a hospice patient entering a NF, unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may be mentally ill or mentally retarded. If the patient is on antipsychotic, antianxiety or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medical groups for a related mental illness, the CMHSP will determine the need for a Level II screening."	Clarification
Hospice	5.3 Transportation	This section was expanded and revised as follows: "**5.3 Transportation** **5.3.A. Home Setting** **Nonemergency** transportation related to the terminal illness is the responsibility of the hospice agency. Routine, nonemergency transportation to obtain Medicaid covered services not related to the terminal illness is available through the local FIA for beneficiaries who do not reside in a nursing facility (NF). The beneficiary/responsible party should contact the FIA worker to determine the appropriate mode of nonemergency transportation and make the necessary arrangements. The transportation provider, not the hospice, bills the local FIA office for the transportation provided. Nonemergency transportation by ambulance not related to the terminal illness requires a physician's signed order to allow the ambulance provider to bill Medicaid directly. **Emergency** transportation related to the terminal illness is the responsibility of the hospice agency. Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.	Information added in response to provider inquiries.

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CHAPTER	SECTION	CHANGE	COMMENT
		5.3.B. Nursing Facility Setting **Nonemergency** transportation related to the terminal illness is the responsibility of the hospice agency. Routine, nonemergency transportation not related to the terminal illness must be provided by the NF as part of their per diem. Nonemergency ambulance transportation not related to the terminal illness requires a physician's signed order and may be billed directly to Medicaid by the ambulance provider. If the NF does not have a physician's order, neither the NF nor the ambulance provider can bill Medicaid, the resident, the resident's family, or use the offset to the patient pay amount. Arrangement for payment is between the NF and the ambulance provider. **Emergency** transportation related to the terminal illness is the responsibility of the hospice agency. Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider. "	
Hospice	6.3.C. Date of Discharge (new subsection added, subsequent subsections renumbered)	The new subsection reads as follows: "Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another, as long as services were provided by both agencies. (This will be randomly verified by post-payment audit and as indicated.) Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge **only** if the discharge is due to resident death. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered as the resident is not there at the midnight census to be counted as a resident. "	Clarification added in response to provider inquiries.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospice	6.3.H. Room and Board to Nursing Facilities	The following bullet was added: • **Memorandum of Understanding (MOU)**. Refer to the Place of Service subsection for information regarding payment of room and board for hospice beneficiaries with an MOU.	Clarification added in response to provider inquiries.
Hospital	5.5 Authorization for Non-DRG Admissions to Freestanding Rehabilitation Hospitals	The Exceptions portion of the table was updated to remove references to Resident County Hospitalization and CSHCS Special Health Plan beneficiaries.	Routine update.
Hospital	5.6 Utilization Review	The subsection was revised as follows to reflect changes in post-payment review activities to be conducted by the Authorization and Certification Review Contractor (ACRC) beginning 10/1/04: "The objective of utilization review is to ensure that care paid by MDCH is medically necessary and provided in the appropriate setting, that the diagnostic and procedural information is valid, and that the care meets quality standards. Post-discharge utilization review of medical/surgical and rehabilitation stays are conducted by the ACRC. Cases are reviewed using Medicaid-approved SI/IS criteria, clinical judgment and generic quality screens. All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The ACRC assures that the quality and intensity of inpatient hospital services conform to acceptable standards of medical practice and to Medicaid policies, procedures, and guidelines." 5.6.A. Intensified Review, was deleted. 5.6.B. Post-Payment Denials was renumbered and revised as 5.7 Post-Payment Review.	Updated to reflect current MDCH audit procedures.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Hospital</td><td>5.7 Post-Payment Review

Subsequent subsections renumbered</td><td>Previously 5.6.B. Post-Payment Denials, this subsection was renumbered and revised to read as follows:

"MDCH may conduct periodic audits of claims, by hospital, to verify that the inpatient hospital medical record supports the level of services billed. If a statistically-valid random sample, by hospital, determines that services billed lacked medical necessity/appropriateness, audit findings may be extrapolated to the entire Medicaid population receiving services in that facility, and are subject to recoupment and/or adjustment.

<table><tr><td>DRG Validity</td><td>The ACRC verifies the diagnosis and procedure codes on the hospital's claim on a post-payment basis for all claims paid on a DRG basis.</td></tr><tr><td>Medical Necessity/ Appropriateness</td><td>The ACRC also performs retrospective review for medical necessity of admissions, transfers and readmissions.</td></tr></table></td><td>Updated to reflect current MDCH audit procedures.</td></tr>
<tr><td>Hospital</td><td>5.8 Quality Review</td><td>The subsection was renumbered from 5.7, and the 1st paragraph revised to read as follows:

"The ACRC performs a review of the quality of care provided to the patient. This review occurs on cases included in the audit sample"</td><td>Updated to reflect current MDCH audit procedures.</td></tr>
<tr><td>Hospital</td><td>Reimbursement Appendix 8.4 GME Pool, and 8.5 Primary Care Pool</td><td>The equations for calculating the distribution of each pool were revised to include the actual dollar amount of each pool (GME Pool - $162.7 million; Primary Care Pool - $20 million).</td><td>Added for clarification</td></tr>
</table>

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.1 MDCH Pharmacy Benefits Manager and Other Vendor Contractors	The list of bullets was revised to read: • Pharmacy Claims Processing Manual for Michigan Medicaid • MPPL • Preferred Drug List (PDL) • Drug Utilization Review (DUR) Meeting Notices • Dose Optimization Program • Pharmacy and Therapeutics (P&T) Committee Meeting Notices • Pharmacy Forms • Maintenance Drug List	Routine update.
Pharmacy	1.2 Definitions	The last sentence of the Compounded Prescription definition was revised to read: "It does not apply to prescriptions dispensed from a previously prepared stock supply (i.e., premaking a special lotion, cream, or ointment in gallons or pounds)." The definition of the Drug Utilization Review Board (DUR Board) was revised to read: "An advisory board to the State's Medicaid Program that includes physicians and pharmacists." The definition for Maximum Allowable Cost (MAC) was revised to read: "The maximum cost allowed by MDCH for certain multiple source brands, generics, cross-licensed drugs and sometimes for sole-source drugs or classes." The definition for Return to Stock was revised to read: "Prescriptions filled but not dispensed or picked up by the beneficiary, and unit dose medication not administered."	Revised for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.5 Outpatient Hospital	The 1st sentence was revised to read: "Outpatient hospitals with pharmacies enrolled with MDCH as pharmacy providers must bill for take-home pharmaceutical products in compliance with policies of this chapter and the MPPL."	Revised for clarification
Pharmacy	1.6.A. Exception for Selected HIV Drugs	The 2nd sentence was revised to read: "These HIV drugs include Protease Inhibitors, Nucleoside/-tide Reverse Transcriptase Inhibitors, and Non-Nucleoside/-tide Reverse Transcriptase Inhibitors, even though the product is related to the terminal illness."	Correction
Pharmacy	2.2 Prescriber Drug Enforcement Agency Number	The subsection was revised as follows: "Pharmacy providers must provide the prescriber's Drug Enforcement Agency (DEA) number on the submitted claim. If the presciber does not have a DEA number, pharmacies must use ZZ11111119."	Correction
Pharmacy	2.3 Sanctioned Prescribers	The 2nd sentence was revised to read: "MDCH does not reimburse for pharmaceuticals prescribed by providers sanctioned by the Federal Government, the State of Michigan, or for prescribers having a limited license (as defined by the Administrative Rules of the Michigan Board of Medicine) or revoked license."	Revised for clarification
Pharmacy	3.1 Compliance with Applicable State, Federal, and MDCH Provisions	The following sentence was added: "MDCH does not enroll dispensing physicians as Medicaid providers for pharmacy services."	Added in response to provider inquiries.
Pharmacy	5.1 Signature Log	The last sentence of the subsection was revised to read: "The absence of the appropriate signature indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy."	Revised for clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 6 – General Noncovered Services	The 1st bullet was revised to read: • Agents used for anorexia or weight loss. The 13th bullet (Legend drugs that become available . . . .) was deleted. The 16th bullet was revised to read: • Drugs recalled by Labelers. The following bullets were added: • Drugs prescribed specifically for medical studies • Drugs discontinued.	Clarification
Pharmacy	7.1 Notification of New Outpatient Drugs	The subsection was revised to read: "MDCH receives weekly, comprehensive new information about outpatient drugs from First Health Databank. Manufacturers are not required to submit notification of new drug products."	Updated to reflect change in process.
Pharmacy	7.2 Approved Labelers	The 1st sentence was revised to read: "MDCH reimburses MPPL products distributed by approved Labelers who have signed rebate agreements with the Centers for Medicare and Medicaid Services (CMS)." The 2nd paragraph was revised to read: "Alcohol swabs, condoms, diaphragms, diabetic reagent strips, dietary formulas, lancets, syringes, aerochambers, spacers and peak flow meters provided by a pharmacy are covered regardless of the manufacturer rebate agreement."	Revised for clarification
Pharmacy	8.1 Prior Authorization	The 2nd sentence of the 1st paragraph was revised to read: "Refer to the PBM's Pharmacy Claims Processing Manual for PA procedures."	Correction

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Pharmacy	8.3.A. Pharmacy Responsibility	The 3rd paragraph was revised to read: "The PBM's Technical Call Center is available 24 hours per day/seven days a week."	Revised for clarification
Pharmacy	8.3.B. Prescriber Responsibility	The 2nd paragraph was revised to read: "The PBM's Clinical Call Center is available after hours by telephone and by pager."	Revised for clarification
Pharmacy	8.4 Documentation Requirements	The 5th bullet was revised to read: • Results of therapeutic alternative medications tried; and	Revised for clarification
Pharmacy	10.1.A. ProDUR Screening Requirements	The 1st paragraph was revised to read: "Before prescriptions are filled or delivered, pharmacists must review the consequences of the drug therapy based on the appropriate standards and guidelines." The bullets following the 1st paragraph were deleted.	Revised for clarification
Pharmacy	10.2 Retrospective Drug Utilization Review	The 1st sentence of the paragraph after the 1st set of bullets was revised to read: "RetroDUR is intended to be an educational tool to reduce costs resulting from drug-induced illnesses and hospitalizations."	Revised for clarification
Pharmacy	11.2 Acute and Maintenance Supplies	The 3rd arrow (A pharmacy may receive a maximum . . .) was deleted. The 1st sentence of the last paragraph was replaced with: "A list of maintenance medication is posted on the PBM's website. (Refer to the Directory Appendix for website information.)"	Revised for clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	11.3 Refills	The subsection was revised to read: "Refills must conform to the current Administrative Rules of the Michigan Board of Pharmacy, Michigan Public Health Code, state and federal statutes, rules, regulations, and policies. Claims will deny at point-of-sale if the utilization requirements have not been met."	Revised for clarification
Pharmacy	11.4 Returned to Stock Prescriptions	The following was added to the beginning of the subsection: "MDCH does not reimburse for prescriptions returned to stock and does not allow restocking fees."	Added for clarification
Pharmacy	13.1 Usual and Customary	The 1st sentence was revised to read: "Reimbursement is the lower of the usual and customary (U&C) charge or MDCH's product cost payment limits and a dispensing fee minus the beneficiary copayment, with the exception of condoms."	Revised for clarification
Pharmacy	13.2 Over the Counter Drugs	The subsection was revised to read: "The U&C charge for prescription-ordered OTC drugs may be different, but not greater, than the retail pharmacy's shelf price of the same product sold without a prescription."	Revised for clarification
Pharmacy	13.4.B. Maximum Allowable Cost	The 2nd paragraph was revised to read: "All requested MAC price reviews require the following information:"	Revised for clarification
Pharmacy	13.7 Nonallowable Charges to the Beneficiary	The 2nd sentence was revised to read: "For all products listed in the MPPL indicating PA is required, the pharmacy may contact the PBM for PA or notify the prescriber that a PA is needed."	Revised for clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	13.10.D. Billing Information	The subsection was revised to read: "For billing information, including NCPDP codes, refer to the PBM's Pharmacy Claims Processing Manual, the PBM's website, or contact the PBM Technical Call Center. (Refer to the Directory Appendix for contact information.)"	Revised for clarification
Pharmacy	14.4.A. Exclusions	The 2nd bullet was revised to read: • Only OTC drugs; or	Revised for clarification
Pharmacy	14.7 Infusion Therapy	The 2nd paragraph was revised to read: "MDCH will reimburse an additional single all-inclusive fee, above the standard dispensing fee, for the diluent and vehicle that is administered with the active ingredient. Refer to the Dispensing Fee subsection for current fee information." The following paragraph was added: "Daily billing for infusion therapy is not allowed. Drugs for infusion therapy must not be billed more frequently than seven days."	Correction/clarification
Pharmacy	14.13 Unit Dose	The 2nd bullet was revised to read: • When the pharmacy cost of the unit dose packaged product is lower than, or equal to, the Michigan Medicaid MAC.	Revised for clarification
Pharmacy	15.2 Unit Dose (NF)	The subsection was revised to read as follows: "Unit dose for oral solids is encouraged for NF beneficiaries, but not mandated. MDCH does not reimburse pharmacies for unit dose liquids. MDCH monitors these policy requirements for unit dose and those listed below on a pre- and post-payment basis.	Revised for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		Nursing Facility pharmacies who have unit dose agreements may be reimbursed for unit dose when the pharmacy: • Bills for the actual quantity consumed by the beneficiary, not the quantity dispensed. • Returns unit dose product dispensed but unused to the pharmacy's inventory for re-use. • Maintains documentation of the quantity dispensed and consumed by the beneficiary, showing a credit to MDCH for drugs not consumed. • Bills for only beneficiaries with the following level of care: 02, 55, and 56. The PBM will enter a Unit Dose specialty and effective date on the pharmacy enrollment record. The Unit Dose Pharmacy Agreement can be obtained from the PBM. (Refer to the Directory Appendix for contact information.)"	
Pharmacy	15.3 Re-Packaged Unit Dose	The 3rd bullet was revised to read: • Conform to the physical standards of the US Pharmacopoeia/National Formulary, FDA Current Good Manufacturing Practices and methods in compliance with the Administrative Rules of the Michigan Board of Pharmacy. The following bullet was added: • Be individually packaged and labeled. MDCH does not reimburse for "bingo cards".	Revised for clarification.
Pharmacy	15.4 Dispensing Fee (new subsection added)	"A pharmacy may receive a maximum of one dispensing fee for the same drug entity per month."	Added for clarification.
Pharmacy	15.8 Returned to Stock Prescriptions (new subsection added)	"MDCH does not reimburse for prescriptions filled but not dispensed to the beneficiary."	Added for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	17.1 Approved Labelers and MPPL	The 1st paragraph was revised to read: "MDCH only covers those drugs produced by Labelers who have signed rebate agreements with the federal government. Products distributed by companies or a division within a company that did not enroll are not covered."	Revised for clarification.
Pharmacy	Section 18 – Beneficiary Monitoring Program	Subsections 18.1, 18.2, and 18.3 were deleted.	Removed obsolete information.
Pharmacy	Section 19 – Pharmacy Audit and Documentation	The following new category was added to the table: "Auditing – MDCH monitors for compliance with Medicaid Policy, the Administrative Rules of the Michigan Board of Pharmacy, the Public Health Code, applicable federal and state regulations, and makes referrals when appropriate. MDCH will recover inappropriate payments made for noncompliant claims identified in post payment review."	Added for clarification
Private Duty Nursing	1.7 Service Log	The log was reformatted to delete the need to report revenue code and HCPCS code. The example was also updated.	Removed obsolete requirement.
Special Programs	Section – 4 Community-Based Long Term Care	Section 4 was renamed from MIChild and MI Choice to Community-Based Long Term Care. It now includes the MI Choice Waiver information, as well as the following information related to the Program of All-Inclusive Care for the Elderly (PACE). MIChild information is now contained in Section 5 – MIChild. **Section 4 – Community-Based Long Term Care** **4.1 MI Choice Waiver** (renumbered from 4.2, no change in content) **4.2 Program of All-Inclusive Care for the Elderly (PACE)** (new)	Routine update

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CHAPTER	SECTION	CHANGE	COMMENT
		PACE is a comprehensive service delivery system for frail, elderly individuals that meet Medicaid's functional/medical criteria for nursing facility level of care. For most PACE participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized. The program uses an Adult Day Care model to provide most services. There is currently only one PACE provider in Michigan—Henry Ford Health System-Center for Senior Independence. **4.2.A. Eligible Beneficiaries** PACE participants must meet the following criteria: • Meet Medicaid's functional/medical criteria for nursing facility level of care • Be at least 55 years of age • Live within the approved geographic area of the PACE organization • Not residing in a nursing facility at the time of enrollment • Not be concurrently enrolled in the Medicaid MI Choice Waiver • Not be concurrently enrolled in a Health Maintenance Organization (HMO) **4.2.B. Covered Services** An interdisciplinary team, consisting of professional and paraprofessional staff, assesses the participants' needs, develops care plans and delivers all services, including acute care services, hospital services, and if necessary, nursing facility services. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participants' needs.	

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Beneficiary Assistance	The following information was added: Beneficiary Helpline (Pharmacy) Phone Number: 877-681-7540 First Health Services Corporation Beneficiaries can receive answers to general pharmacy questions.	
Directory Appendix	Claim Submission/ Payment	The following information was added: Pharmacy Paper Claim Submission First Health Services Corporation 4300 Cox Road Glen Allen, VA 23060 Address to submit paper pharmacy claims.	
Directory Appendix	Provider Resources	Information regarding the State Survey Agency was updated as follows: Phone Number: 517-241-4160 Fax Number: 517-241-3354 Health Facility Licensing & Certification Division Bureau of Health Systems PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 Hospital, ESRD, OPT/CORF, Rural Health Clinic licensing, survey, and certification, Psychiatric Hospital licensing, and Substance Abuse Agency licensing.	

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Directory Appendix	Hospice Resources	The delivery address for the Bureau of Health Systems, Specialized Services Unit has been changed to: 611 W. Ottawa, 1st Floor Lansing, MI 48933	
Directory Appendix	Nursing Facility Resources	The phone/fax numbers for the RAI Coordinator have been changed to the following: Phone: 989-732-8337 fax 989-732-8958	
Directory Appendix	Nursing Facility Resources	The contact information for the State Survey Agency (Nursing Facilities) has been changed to: Phone Number: 517-334-8408 Fax Number: 517-334-8473 Division of Nursing Home Monitoring Bureau of Health Systems PO Box 30664 Lansing, MI 48909 Delivery: 1808 W. Saginaw Lansing, MI 48915	
Directory Appendix	Nursing Facility Resources	The following information was added: Informal Deficiency Dispute Resolution (IDR)/Enforcement Unit Phone: 517-241-2650 Fax Number: 517-241-2635 Enforcement Unit Division of Operations Bureau of Health Systems PO Box 30664 Lansing, MI 48909	

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CHAPTER	SECTION	CHANGE	COMMENT
		www.michigan.gov/mdch , click on Health Systems & Licensing, Bureau of Health Systems, Nursing Home Monitoring Process for submitting informal deficiency dispute resolution requests. Nursing facility enforcement and complaint investigations.	
Directory Appendix	Pharmacy Resources	The following information was added: Refunds, Overpayments, PBM Claims Processing Manual Phone Number: 877-624-5204 Fax Number: 877-888-6370 First Health Services Corp. 4300 Cox Road Glen Allen, VA 23060 Instruction regarding how to submit claims, refunds and overpayments	
Directory Appendix	Other Health Care Resources/Programs	The following information was added: Program of All-Inclusive Care for the Elderly (PACE) 517-335-5202 MDCH Long Term Care Systems Development Section PO Box 30479 Lansing, MI 48909 Information regarding PACE program. Information also available at www.michigan.gov/mdch, , click on Providers, Information for Medicaid Providers	

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 04-13	9/1/04	Medicaid Health Plan	2.8 Child and Adolescent Health Centers and Programs	A new subsection was added to address CAHCP outreach services.
		Special Programs	Section 6 – Child and Adolescent Health Centers and Programs (new)	A brief explanation of CAHCPs was added to the chapter.
CMHSP 04-03	9/1/04	Mental Health/ Substance Abuse (Prepaid Inpatient Health Plans)	2.5 Medical Necessity Criteria (new) Section 17 – Additional Mental Health Services (B3s) (new) Section 18 – Additional Substance Abuse Services (B3s)	Added new sections/subsection.
Private Duty Nursing 04-01	9/1/04	Private Duty Nursing	1.12 Billing for Private Duty Nursing	Information added regarding MI AuthentiCare.
		Billing & Reimbursement for Institutional Providers	Section 10 – Private Duty Nursing Agency Claim Completion	Sections reformatted and information added regarding billing changes for PDN services due to implementation of MI AuthentiCare.
		Billing & Reimbursement for Professionals	6.14 Private Duty Nursing	
		Directory Appendix	Private Duty Nursing Resources (new)	Added new section with MI AuthentiCare related contact information.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
Hospital 04-11	8/23/04	Hospital	Reimbursement Appendix	Subsections 8.4 GME Pool, 8.5 Primary Care Pool, and 8.6 Definitions, were updated. Subsections 8.7 Annual Report and 8.8 Implementation of Weighting Factors were deleted. Subsections 8.9 Three Year Phase-In of Revised GME Formula and 8.10 GME Innovations Grants were renumbered. A new subsection (8.8 Payment Schedule) was added.
Nursing Facility 04-04	8/23/04	Billing & Reimbursement for Institutional Providers	8.13 Other Service Revenue Codes (NF Claim Completion)	Billing instructions for Medicare/Medicaid dual eligibles electing to return to a Medicaid bed instead of a Medicare SNF bed after a qualifying stay.
All Provider 04-12	8/16/04	Entire Manual		The Children's Special Health Care Services (CSHCS) Special Health Plans (SHPs) are terminated effective 10/1/04. All references and policies related to the SHPs have been removed from the manual.
MSA 04-11	8/1/04	Hearing Aid Dealers	1.9 Hearing Aid Evaluation and Selection (new) 1.11 Measurable Benefits/ Hearing Aid Conformity Check (renumbered) subsequent subsections renumbered	Policy changes related to where speech/language and audiology services may be provided, requirements for audiology services provided to beneficiaries of all ages, and requirements for audiology services provided to infants.
		Hearing & Speech Centers	2.1 Hearing Services 2.1.D. Newborn Hearing Services	

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital	3.11 Hearing Services 3.25 Therapy, Speech-Language Pathology	
All Provider 04-10	8/1/04	Children's Special Health Care Services Program	Section 4 – Application Process Section 5 – Financial Determination	Update to the CSHCS application process and financial determinations.

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